MEDICAL PROVIDER REFERRAL FOR DENTAL CARE

REFERRING PROVIDER REPORT:	Provider:	Practice Name	Phone: Fax: Email:
	Address:		
PATIENT INFORMATION:	Patient Name:	Patient DOB:	Phone 1: Phone 2: Email:
	Address:		Parent(s) Name:
	□ Male □ Female	Insurance Information: □ Self Pay/No Coverage □ Medicaid (ID #: _____) □ Commercial (Name: _____)	
PATIENT MEDICAL INFORMATION:	Significant Medical History:		
	Date of Last Fluoride Application: _____/_____/_____ Fluoride Supplements Prescribed: □ Yes □ No	Allergies:	Any prescriptions provided specific to oral issues?
REASON FOR REFERRAL:	Reason for Referral [Select all that apply]: □ Abscess/Infection □ Facial Trauma □ Cavities/Decay □ Issues with gums (swollen/bleeding) □ More than 1 year since last dental visit □ Other: _____		
INTERNAL USE (REFERRAL TRACKING):	Date Referral Sent:	Referring Dental Provider:	Date of Referral Follow Up:

I am the patient or parent/guardian of the patient. I consent to this medical provider sharing information about me / my child with the dentist/dental care team named. I also consent to the dentist/dental care team sharing information about me / my child with this medical provider.

Signature: _____ Date: _____